2026 Farmworker Outreach Health Assessment - Adult (English) | ORW: | Date:

Optional **FHASES ID:** _____ **Cohort:**_____ **Employer:** _____

Privacy

My signature indicates that I understand that my privacy will be protected within this farmworker health network except in the following circumstancs: if harm is suspected of a minor, elderly, or disabled person.

Signature: _____

Demographics

Name (first, last): _____ **Birth date**: ____/____/_____ □ Est.
mm/dd/yyyy

Preferred language: Spanish / English / Other: _____

Do you need an interpreter? Yes/ No

Worker type: Migratory / Seasonal / Other (*If migratory*) **Estimated departure date**: _____

Are you of Hispanic, Latino, or Spanish origin? *Mark all that apply.*
□ Yes, Mexican, Mexican Am., Chicano □ Yes, Puerto Rican □ Yes, Cuban
□ Yes, another Hispanic, Latino, or Spanish origin □ No, not of Hispanic, Latino, or Spanish origin □ Decline to answer

What is your race? *Mark all that apply.*

□ White	□ Vietnamese	□ Korean	□ American Indian or Alaska Native
□ Black or African Am.	□ Filipino	□ Samoan	□ Native Hawaiian
□ Some other race	□ Chamorro	□ Japonese	□ Asian Indian
□ Decline to annswer	□ Chinese	□ Other Asian	□ Other Pacific Islander

What sex were you assigned at birth? Male/ Female

Housing: Own/ Rent/ Grower-provided/ Homeless

Address: _____ **City**: _____ **US veteran?** Sí/ No

State: _____ **Zip code**: _____ **County**: _____

Health insurance: None / Medicaid / Medicare / Health Choice / Private **Family income** ($ amount): _____

Amount is per: week / 2 weeks/ month / year **# months worked** ____ **# family members**: _____

Communication

How can we communicate with you?
Ask patient to initial next to each below if OK.

Cell number: _____
_____ OK to leave a message with another person.
_____ OK to leave a voicemail.
_____ OK to send a text (SMS) even though complete privacy is not guaranteed.
_____ OK to send a message through WhatsApp even though it may not be completely private.
WhatsApp number (if different): _____

How do you prefer that we communicate with you? *Circle preference.*

Emergency contact (optional)
Full name: _____
Phone number: _____
Relationship: _____

Vitals

Blood pressure: _____

Height: _____ **Weight**:_____ **BMI**: ____

If >120/80, offer health ed. If >140/90, offer referral.

Health ed: ☐ Provided ☐ Follow up

Referral: ☐ **Provided** ☐ **Follow up** ☐ **Declined**

General health

Is there something that worries you about your health? No/ Yes:_____

(If yes) **How can I help you with this problem?** _____

Have you ever been diagnosed with a medical condition? No/ Yes:_____

Are you taking (or should you be taking) medicines? No/ Yes:_____

Are you interesed in behavioal health services? No/ Yes:_____

Referral: ☐ Provided ☐ Follow up ☐ Declined
Diabetes, pregnancy, HTN, HIV, TB or abnormal cancer screen, consider MCN*

**Schedule a diabetes departure visit, if needed:* _____

Occupational

Do you work in the fields? No/ Yes

(If yes) **Do you worry about conditions at work?** (like unfair pay, pesticides exposure, or other illegal practices) **No/ Yes:** _____

(If yes) **Would you like more information on how to protect yourself at work?** (such as pesticides, heat stress, or something else) **No/ Yes:** _____

Health ed: □ Provided □ Follow up

Referral: ☐ Provided ☐ Follow up ☐ Declined Health ed topic: _____

MH

Over the last 2 weeks, how often have you been bothered by any of the following problems? (PHQ-2)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

If yes to either question, offer a behavioral health or primary care referral and full depression screen (PHQ-9)

Referral: ☐ Provided ☐ Follow up ☐ Declined

PHQ-9: ☐ Provided ☐ Follow up

Health ed: ☐ Provided ☐ Follow up

Substance use

In the last year, have you smoked or used tobacco products? No / Yes
If yes, provide education & **QUITLINE #: 1-855-335-3569**
Health ed: □ Provided □ Follow up □ Declined

In the last year, have you had more than 4 alcoholic drinks in one sitting? No / Yes
If yes, provide education
Health ed: □ Provided □ Follow up □ Declined

In the last year, have you used any other substane (including marijuana, cocaine, anphetamies [crystal] or opioids)? **No / Yes**
If yes, provide education
Health ed: □ Provided □ Follow up □ Declined

<u>If yes to any question above:</u>
Are you interested in support to help you reduce your use of substances including tobacco and alcohol? No / Yes
If yes, provide referral to primary care or behavioral health services.

Referral: ☐ **Provided** ☐ **Follow up** ☐ **Declined**

CM

Does someone where you work or live threaten you or make you feel in danger? No/ Yes

Do you have any other worries or concerns? No/ Yes: _____

Referral: ☐ **Provided** ☐ **Follow up** ☐ **Declined**

Addtl. Health Ed

Would you like more information on the following topics? *Circle those desired and check off if provided.*

□ COVID-19	□ Emergency preparedness	□ Internet access	□ Telehealth services
□ Dental health	□ Emotional health	□ Nutrition	□ Other(s)_____
□ Diabetes	□ Green Tobacco Sickness	□ STIs/ HIV	
□ Drug or alcohol abuse	□ Hypertension	□ Smoking	

Notes